South Carolina Retirement Systems

SCRS/PORS/ORP

Enrollment

Customer Training Module

Disclaimer

THE LANGUAGE USED IN THIS PRESENTATION DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS PRESENTATION.

This presentation is meant to serve as a guide but does not constitute a binding representation of the South Carolina Retirement Systems. The statutes governing the South Carolina Retirement Systems are found in Title 9 of the South Carolina Code of Laws, and should there be any conflict between this presentation and the statutes or Retirement Systems' policies, the statutes and policies will prevail.

Employers covered by the South Carolina Retirement Systems are not agents of the Retirement Systems.

SCRS Enrollment

South Carolina Retirement System (SCRS) Membership

- **All employees of covered entities, except those specifically exempted by statute, shall become members of the system as a condition of their employment; Section: 9-1-480**
- **Membership is mandatory for all full-time and part-time employees filling a permanent position; Section: 9-1-480**
- **If a member chooses non-membership, they may join SCRS, <u>not</u> the State Optional Retirement Program (State ORP), at any time; Section: 9-1-480**
- **If an employee has funds on deposit in South Carolina Retirement System (SCRS) they may not elect non-membership; Section: 9-1-510 through 9-1-580**
- **If a person does not have funds in an SCRS account, but has funds on account in PORS, GARS, JSRS, NGRS or State ORP, that person may elect to opt out of SCRS membership under S.C. Code Ann. Sections 9-1-510 through 9-1-580**
- **If the employee declines membership and is later hired in a position requiring membership, the employee must then become a member; Section: 9-1-480**
- **If an employee has an account in SCRS or the State Optional Retirement Program (State ORP) they have the option to enroll in the system of their choice, if the new employer is a State ORP eligible employer; Section: 9-1-480, unless it is concurrent employment**
- **If an employee obtains a concurrent position and is a member of SCRS, the employee must elect SCRS for the second position, if the second position is eligible for SCRS; 9-20-40 (A)**
- **Notwithstanding any other provision of law, a contributing member of the SCRS System shall remain a contributing member while under employment to an employer covered by the SCRS System; Section 9-1-425**

Ineligible for Retirement Membership

- **Independent contractors**
- **Students**

SCRS Membership

- **Employees must complete Form 1100 (*Retirement Plan Enrollment*). Form 1100 should be submitted within 30 days of the employee's hire date.**

- **Employees must complete and sign Form 1102 (*Active Member Beneficiary*) or Form 1103 (*Beneficiary/Trustee Designation*) and Form 1113 (*Certification of Trust*).**

Form 1100
Retirement Plan Enrollment Form

Form 1100
Revised 06/06/2005
Page 1

Print or type in black ink and sign in blue ink. Please read the instructions on page 2 before completing this form.

RETIREMENT PLAN ENROLLMENT

State Budget and Control Board
South Carolina Retirement Systems
Attention: Enrollment
Box 11960, Columbia, SC 29211-1960

ACTION REQUESTED (Check One):

- ☒ NEW ENROLLEE (First-time membership)
- ☐ OPEN ENROLLMENT (Irrevocable election from State ORP)
- ☐ CHANGE OF EMPLOYER (Transfer)/DUAL EMPLOYMENT
- ☐ CHANGE OF INFORMATION
  - ☐ Name (Prior Name): _____ (ATTACH LEGAL DOCUMENT INDICATING NAME CHANGE)
  - ☐ Address
  - ☐ SSN (Old Number): _____
  - ☐ Date of Birth

SECTION I: EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)

1. Last Name & Suffix	2. First/ Middle Name	3. Social Security Number (ATTACH A COPY OF YOUR SOCIAL SECURITY CARD.)
DOE	JOHN	000-00-0000

4. Address	5. City	6. State	7. ZIP+4
1 MAIN STREET	COLUMBIA	SC	29229

8. Sex (M=Male F=Female)	9. Date of Birth	10. Telephone Number	11. Have you ever been a member of the South Carolina Retirement Systems?	12. If Item 11 Is "Yes", Indicate the name(s) of your former employer:
M	03-03-1987	803-123-4567	☒ No ☐ Yes	Did you withdraw your contributions? ☐ No ☐ Yes

13. Do you currently have a pending refund request? ☒ No ☐ Yes

14. Are you now receiving or have you applied to receive a monthly benefit from any of the Retirement Systems' retirement plans? ☒ No ☐ Yes ☐ Application In Process

15. Retirement Plan Election: (CHOOSE ONE)
- ☒ SCRS ☐ PORS (See Instructions)
- ☐ State ORP (If State ORP, please complete Item 16.)
- ☐ GARS - Senator (100.01) ☐ GARS - Representative (100.02)
- ☐ JSRS - Judge (001.00) ☐ JSRS - Solicitor (002.00)

16. Select ORP Vendor
- ☐ AIG Valic ☐ CitiStreet ☐ TIAA-CREF
- ☐ The Hartford

17. An employee hired by an eligible employer (school district, higher education, technical college, state department, agency, bureau, commission, and institution) covered under the South Carolina Retirement System (SCRS), may elect to participate in either the traditional defined benefit plan, SCRS, or the optional defined contribution plan, State ORP. The election to participate in State ORP must be made within 30 calendar days after entry into service (date of hire).

If I do not make an election within the required time, I will be considered to have elected membership in SCRS. Participants in the State ORP assume all investment risk. The election to participate in State ORP is irrevocable, except a State ORP participant may make a one-time irrevocable election to join SCRS during any open enrollment period after the first annual anniversary, but before the fifth annual anniversary of the initial enrollment in State ORP.

I understand that, unless a designated beneficiary is on file, my estate will be designated as my beneficiary until the Retirement Systems receives from me a properly executed beneficiary form.

My signature below indicates that my employer has explained the retirement plan options available to me and has provided me with access to information necessary to make an informed choice. My signature on this document confirms my retirement plan election as indicated in block 15 above.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Employee's Signature _____ Date _____ Witness _____ (Required only when signed by mark)

SECTION II: EMPLOYER INFORMATION (TO BE COMPLETED BY THE EMPLOYER)

A COPY OF THE EMPLOYEE'S SOCIAL SECURITY CARD MUST BE ATTACHED TO THIS FORM TO ENROLL THE MEMBER. THE NAME ON THE SOCIAL SECURITY CARD MUST MATCH THE NAME LISTED IN ITEMS 1-2 IN SECTION I OF THIS FORM.

18. Employer Code	19. Employer Name	20. Please Indicate If you are the employee's primary or secondary employer. (Annual member statements are sent to primary employers for distribution to members.)
000.00	ANY EMPLOYER	☒ Primary Employer ☐ Secondary Employer

21. Original Date of Hire with Employer listed in Items 18-19	22. Date of Membership	23. Employee's Position Title	24. Employee's Annual Salary
07-01-2006	07-01-2006	TEACHER	30,000.00

25. I hereby certify that the employee listed in Section I of this form is eligible for the retirement plan selected.

Employer Signature _____ Date _____ _____ Work Telephone Number

For more information, please contact Customer Services at 1-800-868-9002 (in SC only), 803-737-6800, or cs@scrs.state.sc.us

Form 1102
Active Member Beneficiary Form

Form 1102
Revised 03/25/2005
Page 1

Print or type in black ink

Please read the instructions on the reverse (page 2) before completing this form.

ACTIVE MEMBER BENEFICIARY FORM

BENEFICIARY DESIGNATION, CONTINGENT BENEFICARY FOR ACTIVE MEMBERS ONLY- RETIREES USE FORM 7201

South Carolina Retirement Systems
State Budget and Control Board
Box 11960, Columbia, SC 29211-1960

Use for designation of active member beneficiaries and contingent beneficiaries. You may wish to consult with an attorney/estate planner before completing this form.

CHECK ONE:
☒ New Enrollee
☐ Change of Beneficiary

Retirement System (check one)
☒ SCRS ☐ PORS
☐ GARS ☐ JSRS

Section I PERSONAL INFORMATION

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number
DOE	JOHN	000-00-0000

4. Date of Birth	5. Address
03-03-1997	1 MAIN STREET

6. City	7. State	8. ZIP+4
COLUMBIA	SC	29223

ALL SECTIONS MUST BE COMPLETED

Section II-A BENEFICIARY(IES) FOR REFUND OF CONTRIBUTIONS/SURVIVOR BENEFITS - I designate the following **PRIMARY** beneficiary(ies) to receive the Retirement Systems refund of contributions or survivor benefits if eligible.

	Social Security #	Sex	Date of Birth	Relationship
1. Name of Beneficiary (ONE PERSON) JANE DOE	000-00-0000	☐ M ☒ F	09-01-1993	SPOUSE
2. Name of Beneficiary (ONE PERSON)	Social Security #	☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	☐ M ☐ F	Date of Birth	Relationship

Section II-B Contingent Beneficiaries Have No Rights Unless All Primary Beneficiaries Have Died - I designate the following **CONTINGENT** beneficiary(ies) to receive the Retirement Systems refund of contributions or applicable survivor benefits. **If the contingent beneficiary designation below is blank all previous contingent beneficiaries will be revoked and your estate will become your contingent beneficiary.**

	Social Security #	Sex	Date of Birth	Relationship
1. Name of Beneficiary (ONE PERSON) ESTATE		☐ M ☐ F		
2. Name of Beneficiary (ONE PERSON)	Social Security #	☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	☐ M ☐ F	Date of Birth	Relationship

Section III **BENEFICIARY(IES) FOR GROUP LIFE INSURANCE (You may not designate contingent beneficiaries for Group Life) I designate the following beneficiary(ies) to receive the Retirement Systems Group Life Insurance:**

	Social Security #	Sex	Date of Birth	Relationship
1. Name of Beneficiary (ONE PERSON) JANE DOE	000-00-0000	☐ M ☒ F	09-01-1993	SPOUSE
2. Name of Beneficiary (ONE PERSON)	Social Security #	☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	☐ M ☐ F	Date of Birth	Relationship

Section IV CERTIFICATION AND CONDITIONS

IMPORTANT: Please read the Certification and Conditions sections of the instructions on the reverse (page 2) before signing this form. I hereby certify I have read and understand the information on the reverse (page 2), including the certification and conditions, and I agree to the provisions stated.

MEMBER'S SIGNATURE _____ WITNESS _____
(Do not print) (Required only when signed by mark)

STATE OF _____ COUNTY OF _____

Acknowledged before me this date _____ NOTARY NAME _____

My Commission Expires _____ NOTARY SIGNATURE _____
(Out of state, requires Seal)

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Form 1103
Beneficiary/ Trustee Designation Form

Form 1103
Revised 05/22/2001
Page 1
Print or type in black ink

BENEFICIARY/TRUSTEE DESIGNATION FORM

BENEFICIARY DESIGNATION, TRUSTEE DESIGNATION

State Budget and Control Board
South Carolina Retirement Systems
Box 11960, Columbia, SC 29211-1960

Please read the instructions on the reverse (page 2) before completing this form.

Use for designation of beneficiaries and contingent beneficiaries. You may wish to consult with an attorney/estate planner before completing this form.

CHECK ONE:
☒ New Enrollee
☐ Change of Beneficiary

Retirement System (check one)
☒ SCRS ☐ PORS
☐ GARS ☐ JSRS

Section I PERSONAL INFORMATION

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number
DOE	JOHN	000-00-0000

4. Date of Birth	5. Address	
03-03-1987	1 MAIN STREET	

6. City	7. State	8. ZIP+4
COLUMBIA	SC	29229

ALL SECTIONS MUST BE COMPLETED

Section II-A BENEFICIARY(IES) FOR REFUND OF CONTRIBUTIONS/SURVIVOR BENEFITS
I designate the following primary beneficiary(ies) to receive the Retirement Systems refund of contributions or survivor benefits:

1. Name of Trustee(s), (attach Form 1113)	Trust ID, if applicable	Address of Trustee(s)		
JOE DOE		1 RIVER DRIVE, COLUMBIA, SC 29229		
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex	Date of Birth	Relationship
JOHN DOE JR.	000-00-0001	☒ M ☐ F	12-31-2004	SON
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON) (not requiring trustee)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section II-B Contingent Beneficiaries Have No Rights Unless All Primary Beneficiaries Have Died
I designate the following contingent beneficiary(ies) to receive the Retirement Systems refund of contributions or survivor benefits:

1. Name of Trustee(s), (attach Form 1113)	Trust ID, if applicable	Address of Trustee(s)		
ESTATE				
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON) (not requiring trustee)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section III BENEFICIARY(IES) FOR GROUP LIFE INSURANCE (You may not designate contingent beneficiaries for Group Life)
I designate the following beneficiary(ies) to receive the Retirement Systems Group Life Insurance:

1. Name of Trustee(s), (attach Form 1113)	Trust ID, if applicable	Address of Trustee(s)		
JOE DOE		1 RIVER DRIVE, COLUMBIA, SC 29229		
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex	Date of Birth	Relationship
JOHN DOE JR.	000-00-0001	☒ M ☐ F	12-31-2004	SON
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON) (not requiring trustee)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section IV CERTIFICATION AND CONDITIONS

IMPORTANT: Please read the Certification and Conditions sections of the instructions on the reverse (page 2) before signing this form. I hereby certify I have read and understand the information on the reverse (page 2), including the certification and conditions, and I agree to the provisions stated.

MEMBER'S SIGNATURE _____ WITNESS _____
(Do not print) (Required only when signed by mark)

STATE OF _____ COUNTY OF _____

Acknowledged before me this date _____ NOTARY NAME _____

My Commission Expires _____ NOTARY SIGNATURE _____
(Out of state, requires Seal)

Please call SC Retirement Systems Customer Service with any questions: 800/868-9002 (in state) or 803/737-6800

Form 1113
Certificate of Trust

Form 1113
05/29/2002
Page 1 of 2

CERTIFICATION OF TRUST

State Budget and Control Board
South Carolina Retirement Systems
Attention: Enrollment
Box 11960, Columbia, SC 29211-1960

Retirement Plan (check one)
☒ SCRS ☐ PORS
☐ JSRS ☐ GARS
☐ State ORP

PERSONALLY APPEARED before me, JOHN DOE
(Member Name)
(SSN: 000-00-0000), who being duly sworn, deposes and says:

1. I certify that I desire to designate a trust to receive my South Carolina Retirement Systems benefits.

2. I certify that the following person will serve as Trustee of my trust: ANN STONE
(Trustee Name)
3 MAIN STREET (Trustee Address) 803-000-1111 (Trustee Telephone)

3. I certify that the following person(s) are beneficiary(ies) of the trust:

	Social Security #	Date of Birth
a. Name of Beneficiary: JANE DOE	111-11-1111	09-01-2005 (MM-DD-YYYY)
b. Name of Beneficiary:		(MM-DD-YYYY)
c. Name of Beneficiary:		(MM-DD-YYYY)
d. Name of Beneficiary:		(MM-DD-YYYY)

MEMBER'S SIGNATURE _____ (Do not print) WITNESS _____ (Required only when signed by mark)

STATE OF _____ COUNTY OF _____

ACKNOWLEDGED BEFORE ME THIS DATE _____ NOTARY NAME _____

MY COMMISSION EXPIRES _____ NOTARY SIGNATURE _____ (Out of state requires Seal)

Please call SC Retirement Systems Customer Service with any questions: 800/868-9002 (in state) or 803/737-6800

SCRS
Election of Non-Membership

SCRS Election of Non-Membership

(Excluding Retirees Returning to Covered Employment)

- **School bus driver**
- **Earned compensation below $100 per month**
- **Non-permanent position**
- **Day laborer**
- **Hospital worker**
- **Elected Official**

Employees in the above categories have the option of electing non-membership. Form 1104 (*Election of Non-Membership*) should be submitted within 30 days of the employee's hire date.

If an employee has funds on deposit in South Carolina Retirement System (SCRS) they may not elect non-membership under Sections: 9-1-425; and 9-1-510 through 9-1-580

Form 1104
Election of Non-Membership

Form 1104
Revised 07/11/2005
Page 1

Print or type in black ink and sign in blue ink. Please read the instructions on page 2 before completing this form.

ELECTION OF NON-MEMBERSHIP

State Budget and Control Board
South Carolina Retirement Systems
Attention: Enrollment
Box 11960, Columbia, SC 29211-1960

SECTION I EMPLOYEE INFORMATION

If you currently have funds on deposit in the Retirement Systems, you may not elect non-membership.

1. Last Name & Suffix (PLEASE PRINT)	2. First/Middle Name (PLEASE PRINT)	3. Social Security Number
DOE	JOHN	000-00-0000

4. Address	5. City	6. State	7. ZIP+4
1 MAIN STREET	COLUMBIA	SC	29229

8. Sex	9. Date of Birth	10. Date of Employment	11. Position Title	12. Present Monthly Salary
☒ M ☐ F	03-03-1987	07-01-2006	COMPUTER TECHNICIAN	25,000.00

SECTION II EMPLOYEE CERTIFICATION AND SIGNATURE

I understand that an employee hired by an eligible employer (school district, higher education, technical college, state department, agency, bureau, commission, and institution) covered under the South Carolina Retirement System (SCRS), who is not receiving benefits as a retired member, may elect to participate in either the traditional defined benefit plan, SCRS, or the optional defined contribution plan, State ORP. The election to participate in State ORP must be made within 30 calendar days after entry into service (date of hire). An employee who elects non-membership may not later opt into State ORP if the 30-day window of election has expired; however, if an employee experiences a break in service and is rehired, he would again be eligible to make an election within 30 calendar days from the subsequent date of hire.

I hereby notify you that I am an employee of the state of South Carolina or its political subdivisions, and that I meet the requirements to elect non-membership in the Retirement Systems, and I hereby exercise my option to elect non-membership.

I take this action under the provisions of the Retirement Act with full knowledge that I will not be credited with retirement service for this period of employment since I have elected non-membership.

I also certify that the information provided in items 1-12 of Section I of this form are true to the best of my knowledge and belief.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Employee Signature: _____ Date: _____

SECTION III EMPLOYMENT CATEGORY (TO BE COMPLETED BY THE EMPLOYER)

If the employee's position qualifies him or her to elect non-membership, please mark the appropriate box. If an employee currently has funds on deposit in the Retirement Systems, the employee may not elect non-membership.

CATEGORY (SEE DESCRIPTIONS ON PAGE 2)	SCRS	PORS	GARS
Non-Permanent Position	☒		
Optional Membership - Exemptions Authorized by the Retirement Act	☐		
Elected Official Earning $9,000 or less per Year	☐	☐	
Employee Earning Less than $2,000 and working fewer than 1,600 hours in a Year		☐	
Active General Assembly Member retired under JSRS or receiving GARS benefits at age 70 or after 30 years service			☐
Retired Justice/Judge returning to work for public institution of education	☐		

I hereby certify that the employee listed in items 1-2 of Section I of this form meets the requirements to elect non-membership.

Employer Name: ANY EMPLOYER Employer Code: 000.00

Employer Signature: _____ Date: _____

Title: BENEFITS ADMINISTRATOR Work Telephone: 803-123-4567

Please call SC Retirement Systems Customer Service with any questions: (800) 868-9002 (in state) or (803) 737-6800

ORP Enrollment

State ORP

- **All state, public school and higher education employees hired after June 30, 2003, are eligible to choose State ORP. This includes all permanent full-time employees, temporary, part-time employees and political appointees**
- **An employee hired by an eligible employer (school district, higher education, technical college, state agency) may elect to participate in either the traditional defined benefit plan (SCRS), or the optional defined contribution plan (State ORP).**
- **Employees in the above categories must complete Form 1100 (*Retirement Plan Enrollment*). Employees must choose either SCRS or State ORP and a vendor. Form 1100 should be submitted within 30 days of the employee's hire, or the employee defaults to SCRS.**
- **An employee, who is receiving a distribution of benefits from an ORP provider and is employed in a position eligible for membership in SCRS, must enroll in either SCRS or ORP, unless a statutory exemption applies.**
- **If an employee has an account in SCRS or the State Optional Retirement Program (State ORP) they have the option to enroll in the system of their choice, if the new employer is a State ORP eligible employer; Section: 9-1-480, unless it is concurrent employment**
- **If an employee obtains a concurrent position and is a member of ORP, the employee must elect ORP for the second position, if the second position is eligible for ORP; 9-20-40 (A)**
- **Notwithstanding any other provision of law, a contributing member of the SCRS System shall remain a contributing member while under employment to an employer covered by the SCRS System; Section 9-1-425.**
- **Employees must complete and sign Form 1106 (*State ORP Active Group Life Beneficiary Designation*).**

State ORP
Open Enrollment

Open enrollment is held each January 1- March 1 During this time members may:

- **Change investment providers**
- **Irrevocably switch to SCRS if the member has between one and five years of State ORP service**

To make changes, members must complete and sign Form 1162 (*State ORP Notice of Termination or Change*).

Form 1100
Retirement Plan Enrollment Form

Form 1100
Revised 06/06/2005
Page 1

RETIREMENT PLAN ENROLLMENT

State Budget and Control Board
South Carolina Retirement Systems
Attention: Enrollment
Box 11960, Columbia, SC 29211-1960

Print or type in black ink and sign in blue ink. Please read the instructions on page 2 before completing this form.

ACTION REQUESTED (Check One):

- ☒ NEW ENROLLEE (First-time membership)
- ☐ OPEN ENROLLMENT (Irrevocable election from State ORP)
- ☐ CHANGE OF EMPLOYER (Transfer)/DUAL EMPLOYMENT
- ☐ CHANGE OF INFORMATION
  - ☐ Name (Prior Name): _____ (ATTACH LEGAL DOCUMENT INDICATING NAME CHANGE)
  - ☐ Address
  - ☐ SSN (Old Number): _____
  - ☐ Date of Birth

SECTION I: EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)

1. Last Name & Suffix	2. First/ Middle Name	3. Social Security Number (ATTACH A COPY OF YOUR SOCIAL SECURITY CARD.)
DOE	JOHN	000-00-0000

4. Address	5. City	6. State	7. ZIP+4
1 MAIN STREET	COLUMBIA	SC	29229

8. Sex (M=Male, F=Female)	9. Date of Birth	10. Telephone Number	11. Have you ever been a member of the South Carolina Retirement Systems?	12. If Item 11 is "Yes", indicate the name(s) of your former employer:
M	03-03-1987	803-123-4567	☒ No ☐ Yes	Did you withdraw your contributions? ☐ No ☐ Yes

13. Do you currently have a pending refund request? ☒ No ☐ Yes

14. Are you now receiving or have you applied to receive a monthly benefit from any of the Retirement Systems' retirement plans? ☒ No ☐ Yes ☐ Application in Process

15. Retirement Plan Election: (CHOOSE ONE)
- ☐ SCRS ☐ PORS (See Instructions)
- ☒ State ORP (If State ORP, please complete Item 16.)
- ☐ GARS - Senator (100.01) ☐ GARS - Representative (100.02)
- ☐ JSRS - Judge (001.00) ☐ JSRS - Solicitor (002.00)

16. Select ORP Vendor
- ☐ AIG Valic ☐ CitiStreet ☐ TIAA-CREF
- ☒ The Hartford

17. An employee hired by an eligible employer (school district, higher education, technical college, state department, agency, bureau, commission, and institution) covered under the South Carolina Retirement System (SCRS), may elect to participate in either the traditional defined benefit plan, SCRS, or the optional defined contribution plan, State ORP. The election to participate in State ORP must be made within 30 calendar days after entry into service (date of hire).

If I do not make an election within the required time, I will be considered to have elected membership in SCRS. Participants in the State ORP assume all investment risk. The election to participate in State ORP is irrevocable, except a State ORP participant may make a one-time irrevocable election to join SCRS during any open enrollment period after the first annual anniversary, but before the fifth annual anniversary of the initial enrollment in State ORP.

I understand that, unless a designated beneficiary is on file, my estate will be designated as my beneficiary until the Retirement Systems receives from me a properly executed beneficiary form.

My signature below indicates that my employer has explained the retirement plan options available to me and has provided me with access to information necessary to make an informed choice. My signature on this document confirms my retirement plan election as indicated in block 15 above.

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Employee's Signature _____ Date _____ Witness _____ (Required only when signed by mark)

SECTION II: EMPLOYER INFORMATION (TO BE COMPLETED BY THE EMPLOYER)

A COPY OF THE EMPLOYEE'S SOCIAL SECURITY CARD MUST BE ATTACHED TO THIS FORM TO ENROLL THE MEMBER. THE NAME ON THE SOCIAL SECURITY CARD MUST MATCH THE NAME LISTED IN ITEMS 1-2 IN SECTION I OF THIS FORM.

18. Employer Code	19. Employer Name	20. Please indicate if you are the employee's primary or secondary employer. (Annual member statements are sent to primary employers for distribution to members.)
000.00	ANY EMPLOYER	☒ Primary Employer ☐ Secondary Employer

21. Original Date of Hire with Employer listed in Items 18-19	22. Date of Membership	23. Employee's Position Title	24. Employee's Annual Salary
07-01-2006	07-01-2006	TEACHER	30,000.00

25. I hereby certify that the employee listed in Section I of this form is eligible for the retirement plan selected.

Employer Signature _____ Date _____ Work Telephone Number _____

For more information, please contact Customer Services at 1-800-868-9002 (in SC only), 803-737-6800, or cs@scrs.state.sc.us

Form 1106
State ORP Active Group Life Beneficiary Form

Form 1106
Revised 06/07/2002

STATE ORP ACTIVE GROUP LIFE BENEFICIARY DESIGNATION

South Carolina Retirement Systems
State Budget and Control Board
Attention: Enrollment
Box 11960, Columbia, SC 29211-1960

Print or type in black ink

Please read the instructions on page 2 before completing this form.

CHECK ONE:
☒ State ORP New Enrollee
☐ State ORP Active Group Life Beneficiary Change

Section I — PERSONAL INFORMATION

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number
DOE	JOHN	000-00-0000

4. Date of Birth	5. Address
09-01-1983	1 MAIN STREET

6. City	7. State	8. ZIP+4
COLUMBIA	SC	29223

Section II — BENEFICIARY(IES) FOR ACTIVE GROUP LIFE INSURANCE

I designate the following beneficiary(ies) to receive the State ORP Group Life Insurance:

1. Name of Beneficiary (ONE PERSON) JANE DOE	Social Security # 000-00-0000	Sex ☐ M ☒ F	Date of Birth 09-01-1983	Relationship SPOUSE
2. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
4. Name of Trustee(s), (attach Form 1113)	Trust ID, if applicable	Address of Trustee(s)		
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section III — CERTIFICATION AND CONDITIONS

IMPORTANT:
Please read the Certification and Conditions section of the instructions on page 2 before signing this form. I hereby certify I have read and understand the information on page 2, including the certification and conditions, and I agree to the provisions stated.

MEMBER'S SIGNATURE _____ WITNESS _____
(Do not print) (Required only when signed by mark)

STATE OF _____ COUNTY OF _____

ACKNOWLEDGED BEFORE ME THIS DATE_____ NOTARY NAME _____

MY COMMISSION EXPIRES_____ NOTARY SIGNATURE _____
(Out of state, requires Seal)

Please call SC Retirement Systems Customer Service with any questions: 800/868-9002 (in state) or 803/737-6800

Form 1162
State ORP Notice of Termination or Change Form

Form 1162
Revised 06/07/2002

Print or type in black ink

STATE OPTIONAL RETIREMENT PROGRAM (STATE ORP)

NOTICE OF TERMINATION OR CHANGE
State Budget and Control Board
South Carolina Retirement Systems
Attention: Enrollment
Box 11960, Columbia, SC 29211-1960

SECTION I — EMPLOYEE INFORMATION

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number
DOE	JOHN	000-00-0000

4. Address: 1 MAIN STREET

5. City	6. State	7. Zip + 4
COLUMBIA	SC	29229

8. Current Vendor Name: THE HARTFORD

SECTION II — REASON FOR CHANGE

☐ CHANGE IN EMPLOYEE INFORMATION

☐ TERMINATION Effective Date: _____

☒ VENDOR CHANGE

New Vendor: AIG VALIC Effective Date: 4-1-2006

SECTION III — TO BE COMPLETED BY EMPLOYEE AND EMPLOYER

Employee's Signature: _____ Effective Date: 4-1-2006

Employer Name: ANY EMPLOYER Employer Code: 000.00

Authorized Employer Signature: _____

Telephone #: 803-123-4567 Date: 2/1/2006

Return completed form to the SC Retirement Systems (see address above)
Please call SC Retirement Systems Customer Service with any questions: 800/868-9002 (in state) or 803/737-6800

State ORP Vendors

Richard Snyder
The Hartford
50 Glenlake Parkway
Atlanta, GA 30328
(888) 897-2677 Office
(800) 528-9009 (Service Center)
sc.orp@hartfordlife.com

David A. Johnson
CitiStreet/MetLife
10130 Mallard Creek Road
Charlotte, NC 28262
(704) 549-0297 Office
djohnson14@metlife.com

Carl H. Goodwin
TIAA-CREF Individual & Institutional Services, LLC.
Six Concourse Parkway
Suite 2600
Atlanta, GA 30328
(800) 842-2003
cgoodwin@tiaa-cref.org

Mandy Yelton
AIG VALIC
3710 Landmark Drive, Suite 104
Columbia, SC 29204
(803) 743-2020
mandy_yelton@aigvalic.com

Retirement System's Forms Flow

New Hire

Review resources: video, SCRS/PORS brochure, State ORP/SCRS comparison brochure, Investment education brochure, Web site benefit comparison calculator

Enroll (within 30 days)

SCRS/PORS

1100 – Retirement Plan Enrollment
1102 –Active Member Beneficiary Designation
1103 – Beneficiary/Trustee Designation
1104 – Election of Non-Membership
1113 – Certification of Trust
1114 – Notification of Employed Retiree

State ORP
Except political subdivisions, PORS, GARS, and JSRS

1100 – Retirement Plan Enrollment
1103 – Beneficiary/Trustee Designation
1106 – Active Group Life Beneficiary Designation
1113 – Certification of trust
1162 – Change of Vendor/Termination

New hire selects SCRS	New hire eligible for PORS	New hire selects State ORP	Retiree returns to covered employment	New hire declines membership
Complete & Sign Retirement Plan Enrollment Form 1100	Complete & Sign Retirement Plan Enrollment Form 1100	Complete & Sign Retirement Plan Enrollment Form 1100	Complete & Sign Notification of Employed Retiree Form 1114	Complete & Sign Election of Non-Membership Retiree Form 1104
Complete & Sign Beneficiary Designation Form 1102 or Beneficiary/ Trustee Designation Form 1103 and Certification of Trust Form 1113	Complete & Sign Beneficiary Designation Form 1102 or Beneficiary/ Trustee Designation Form 1103 and Certification of Trust Form 1113	Complete & Sign State ORP Active Group Life Beneficiary Designation Form 1106	Complete & Sign Retired Member Change of Beneficiary	
		Complete/Mail vendor application form to State ORP vendor		
Mail Form 1100 & Form 1102, or Forms 1103 & 1113, & copy of SSN card to SCRS	Mail Form 1100 & Form 1102, or Forms 1103 & 1113, & copy of SSN card to SCRS	Mail Form 1100 & Form 1106 copy of SSN card to SCRS	Mail Form 1114 and Form 7201 copy of SSN card to SCRS	Mail Form 1104 & copy of SSN card to SCRS
		Mail Form 1100 to CG if new hire at a state agency; if not, mail to State ORP vendor		

PORS Enrollment

Police Officers Retirement System (PORS) Membership

SC State Code of Laws (Section: 9-11-40)

- **All persons who become employed as police officers and/or firemen by the state or other employer after the employer's date of admission in to the system under the provisions of this section shall become members as a condition of their employment.**

- **If an employee is currently active in PORS with another employer, he must continue his membership with the concurrent employer, if the concurrent employer has PORS coverage.**

- **If a person does not have funds in an SCRS account, but has funds on account in PORS, GARS, JSRS, NGRS or State ORP, that person may elect to opt out of SCRS membership under S.C. Code Ann. Sections 9-1-510 through 9-1-580**

PORS
Eligible Membership

- Police officers
- Firefighters
- Magistrates (effective: January 1, 2001)
- SC Department of Corrections, SC Department of Juvenile Justice, or SC Department of Mental Health Peace Officers
- Probate judges may elect PORS
- Coroners

PORS Membership

To be a PORS member, the employer must be a PORS covered employer and the employee must meet the following criteria:
Employees must be required by the terms of their employment to give their time to the:

POLICE OFFICERS	**FIREFIGHTERS**
Title 9, Chapter 11 of S.C. Code of Laws	**9-1-660**
Preservation of public order	**Prevention and**
Protection of life and property	**Control of property**
Detection of crimes in the state	**destruction by fire**

Police Officers and Firefighters are required to:

Work 1,600 hours per year
Earn at least $2,000 per fiscal year

PORS membership consists of police officers; firefighters; magistrates; SCDOC, SCDJJ, and SCDMH peace officers; probate judges; and coroners. Probate judges may elect either SCRS or PORS

- **Employees meeting the above requirements must complete Form 1100 (*Retirement Plan Enrollment*). Form 1100 should be submitted within 30 days of the employee's hire date.**
- **Employers must certify that the employees meet the above criteria by completing Form 1107 (*Employer Certification of Police Officers Retirement System (PORS) Eligibility*).**
- **Employees must complete and sign Form 1102 (*Active Member Beneficiary Designation)* or Form 1103 (*Beneficiary/Trustee Designation*) and Form 1113 (*Certification of Trust*).**

Form 1100
Retirement Plan Enrollment Form

Form 1100
Revised 06/06/2005
Page 1

RETIREMENT PLAN ENROLLMENT

State Budget and Control Board
South Carolina Retirement Systems
Attention: Enrollment
Box 11960, Columbia, SC 29211-1960

Print or type in black ink and sign in blue ink. Please read the instructions on page 2 before completing this form.

ACTION REQUESTED (Check One):

- ☒ NEW ENROLLEE (First-time membership)
- ☐ OPEN ENROLLMENT (Irrevocable election from State ORP)
- ☐ CHANGE OF EMPLOYER (Transfer)/DUAL EMPLOYMENT
- ☐ CHANGE OF INFORMATION
  - ☐ Name (Prior Name): _____ (ATTACH LEGAL DOCUMENT INDICATING NAME CHANGE)
  - ☐ Address
  - ☐ SSN (Old Number): _____
  - ☐ Date of Birth

SECTION I: EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)

1. Last Name & Suffix	2. First/ Middle Name	3. Social Security Number (ATTACH A COPY OF YOUR SOCIAL SECURITY CARD.)
DOE	JOHN	000-00-0000

4. Address	5. City	6. State	7. ZIP+4
1 MAIN STREET	COLUMBIA	SC	29229

8. Sex (M=Male, F=Female)	9. Date of Birth	10. Telephone Number	11. Have you ever been a member of the South Carolina Retirement Systems?	12. If Item 11 is "Yes", indicate the name(s) of your former employer:
M	03-03-1987	803-123-4567	☒ No ☐ Yes	Did you withdraw your contributions? ☐ No ☐ Yes

13. Do you currently have a pending refund request? ☒ No ☐ Yes

14. Are you now receiving or have you applied to receive a monthly benefit from any of the Retirement Systems' retirement plans? ☒ No ☐ Yes ☐ Application in Process

15. Retirement Plan Election: (CHOOSE ONE)
- ☐ SCRS
- ☒ PORS (See Instructions)
- ☐ State ORP (If State ORP, please complete item 16.)
- ☐ GARS - Senator (100.01)
- ☐ GARS - Representative (100.02)
- ☐ JSRS - Judge (001.00)
- ☐ JSRS - Solicitor (002.00)

16. Select ORP Vendor
- ☐ AIG Valic
- ☐ CitiStreet
- ☐ TIAA-CREF
- ☐ The Hartford

17. An employee hired by an eligible employer (school district, higher education, technical college, state department, agency, bureau, commission, and institution) covered under the South Carolina Retirement System (SCRS), may elect to participate in either the traditional defined benefit plan, SCRS, or the optional defined contribution plan, State ORP. The election to participate in State ORP must be made within 30 calendar days after entry into service (date of hire).

If I do not make an election within the required time, I will be considered to have elected membership in SCRS. Participants in the State ORP assume all investment risk. The election to participate in State ORP is irrevocable, except a State ORP participant may make a one-time irrevocable election to join SCRS during any open enrollment period after the first annual anniversary, but before the fifth annual anniversary of the initial enrollment in State ORP.

I understand that, unless a designated beneficiary is on file, my estate will be designated as my beneficiary until the Retirement Systems receives from me a properly executed beneficiary form.

My signature below indicates that my employer has explained the retirement plan options available to me and has provided me with access to information necessary to make an informed choice. My signature on this document confirms my retirement plan election as indicated in block 15 above.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Employee's Signature _____ Date _____ Witness _____ (Required only when signed by mark)

SECTION II: EMPLOYER INFORMATION (TO BE COMPLETED BY THE EMPLOYER)

A COPY OF THE EMPLOYEE'S SOCIAL SECURITY CARD MUST BE ATTACHED TO THIS FORM TO ENROLL THE MEMBER. THE NAME ON THE SOCIAL SECURITY CARD MUST MATCH THE NAME LISTED IN ITEMS 1-2 IN SECTION I OF THIS FORM.

18. Employer Code	19. Employer Name	20. Please indicate if you are the employee's primary or secondary employer. (Annual member statements are sent to primary employers for distribution to members.)
000.00	ANY EMPLOYER	☒ Primary Employer ☐ Secondary Employer

21. Original Date of Hire with Employer listed in Items 18-19	22. Date of Membership	23. Employee's Position Title	24. Employee's Annual Salary
07-01-2006	07-01-2006	SECURITY GUARD	30,000.00

25. I hereby certify that the employee listed in Section I of this form is eligible for the retirement plan selected.

Employer Signature _____ Date _____ Work Telephone Number _____

For more information, please contact Customer Services at 1-800-868-9002 (in SC only), 803-737-6800, or cs@scrs.state.sc.us

Form 1107
Employer Certification of Police Officers Retirement System (PORS) Eligibility

Form 1107
07/26/2004

EMPLOYER CERTIFICATION OF POLICE OFFICERS RETIREMENT SYSTEM (PORS) ELIGIBILITY

State Budget and Control Board
South Carolina Retirement Systems
Box 11960, Columbia, SC 29211-1960

PERSONALLY APPEARED before me, BOB DOE, who being duly sworn, deposes and says:

1. I am the CHIEF OF SECURITY (TITLE) of ANY AGENCY (AGENCY);

2. That in my capacity as CHIEF OF SECURITY, I am familiar with the duties and responsiblities of the employees of ANY AGENCY

3. I certify that JOHN DOE is a participating employer in the Police Officers Retirement System;

4. I certify that JOHN DOE (EMPLOYEE) (SSN# 000-00-000) is an employee of ANY AGENCY and currently holds the position of GAME WARDEN;

5. I certify that in his/her capacity of GAME WARDEN, he/she is required by the terms of their employment to give time to: a) the preservation of public order, the protection of life and property and the detection of crimes; or b) the prevention and control of property destruction by fire.

6. I certify that as a GAME WARDEN, he/she is required to devote at least 1,600 hours per year of active duty performing the "police officer" or "fireman" duties listed in paragraph 5 above, and that he/she receives at least $2,000 salary per year for these duties in accordance with Section 9-11-40(4) or Section 9-1-660.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

EMPLOYER'S SIGNATURE _____ (Do not print)

STATE OF _____ COUNTY OF _____

ACKNOWLEDGED BEFORE ME THIS DATE _____ NOTARY NAME _____

MY COMMISSION EXPIRES _____ NOTARY SIGNATURE _____ (Out of state requires Seal)

This form must be completed for any PORS member other than a magistrate or a probate judge.

Please call SC Retirement Systems Customer Service with any questions: 800/868-9002 (in state) or 803/737-6800

Form 1102
Active Member Beneficiary Form

Form 1102
Revised 03/25/2005
Page 1

Print or type in black ink

Please read the instructions on the reverse (page 2) before completing this form.

ACTIVE MEMBER BENEFICIARY FORM

BENEFICIARY DESIGNATION, CONTINGENT BENEFICARY FOR ACTIVE MEMBERS ONLY- RETIREES USE FORM 7201

South Carolina Retirement Systems
State Budget and Control Board
Box 11960, Columbia, SC 29211-1960

Use for designation of active member beneficiaries and contingent beneficiaries. You may wish to consult with an attorney/estate planner before completing this form.

CHECK ONE:
☒ New Enrollee
☐ Change of Beneficiary

Retirement System (check one)
☐ SCRS ☒ PORS
☐ GARS ☐ JSRS

Section I PERSONAL INFORMATION

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number
DOE	JOHN	000-00-0000

4. Date of Birth	5. Address
03-03-1997	1 MAIN STREET

6. City	7. State	8. ZIP+4
COLUMBIA	SC	29223

ALL SECTIONS MUST BE COMPLETED

Section II-A BENEFICIARY(IES) FOR REFUND OF CONTRIBUTIONS/SURVIVOR BENEFITS - I designate the following **PRIMARY** beneficiary(ies) to receive the Retirement Systems refund of contributions or survivor benefits if eligible.

	Social Security #	Sex	Date of Birth	Relationship
1. Name of Beneficiary (ONE PERSON) JANE DOE	000-00-0000	☐ M ☒ F	09-01-1993	SPOUSE
2. Name of Beneficiary (ONE PERSON)	Social Security #	☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	☐ M ☐ F	Date of Birth	Relationship

Section II-B Contingent Beneficiaries Have No Rights Unless All Primary Beneficiaries Have Died - I designate the following **CONTINGENT** beneficiary(ies) to receive the Retirement Systems refund of contributions or applicable survivor benefits. **If the contingent beneficiary designation below is blank all previous contingent beneficiaries will be revoked and your estate will become your contingent beneficiary.**

	Social Security #	Sex	Date of Birth	Relationship
1. Name of Beneficiary (ONE PERSON) ESTATE		☐ M ☐ F		
2. Name of Beneficiary (ONE PERSON)	Social Security #	☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	☐ M ☐ F	Date of Birth	Relationship

Section III **BENEFICIARY(IES) FOR GROUP LIFE INSURANCE (You may not designate contingent beneficiaries for Group Life) I designate the following beneficiary(ies) to receive the Retirement Systems Group Life Insurance:**

	Social Security #	Sex	Date of Birth	Relationship
1. Name of Beneficiary (ONE PERSON) JANE DOE	000-00-0000	☐ M ☒ F	09-01-1993	SPOUSE
2. Name of Beneficiary (ONE PERSON)	Social Security #	☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	☐ M ☐ F	Date of Birth	Relationship

Section IV CERTIFICATION AND CONDITIONS

IMPORTANT: Please read the Certification and Conditions sections of the instructions on the reverse (page 2) before signing this form. I hereby certify I have read and understand the information on the reverse (page 2), including the certification and conditions, and I agree to the provisions stated.

MEMBER'S SIGNATURE _____ WITNESS _____
(Do not print) (Required only when signed by mark)

STATE OF _____ COUNTY OF _____

Acknowledged before me this date _____ NOTARY NAME _____

My Commission Expires _____ NOTARY SIGNATURE _____
(Out of state, requires Seal)

Form 1103
Beneficiary/ Trustee Designation Form

Form 1103
Revised 05/22/2001
Page 1
Print or type in black ink

BENEFICIARY/TRUSTEE DESIGNATION FORM

BENEFICIARY DESIGNATION, TRUSTEE DESIGNATION

State Budget and Control Board
South Carolina Retirement Systems
Box 11960, Columbia, SC 29211-1960

Please read the instructions on the reverse (page 2) before completing this form.

Use for designation of beneficiaries and contingent beneficiaries. You may wish to consult with an attorney/estate planner before completing this form.

CHECK ONE:
☒ New Enrollee
☐ Change of Beneficiary

Retirement System (check one)
☐ SCRS ☒ PORS
☐ GARS ☐ JSRS

Section I PERSONAL INFORMATION

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number
DOE	JOHN	000-00-0000

4. Date of Birth	5. Address	
03-03-1987	1 MAIN STREET	

6. City	7. State	8. ZIP+4
COLUMBIA	SC	29229

ALL SECTIONS MUST BE COMPLETED

Section II-A BENEFICIARY(IES) FOR REFUND OF CONTRIBUTIONS/SURVIVOR BENEFITS
I designate the following primary beneficiary(ies) to receive the Retirement Systems refund of contributions or survivor benefits:

1. Name of Trustee(s), (attach Form 1113)	Trust ID, if applicable	Address of Trustee(s)		
JOE DOE		1 RIVER DRIVE, COLUMBIA, SC 29229		
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex	Date of Birth	Relationship
JOHN DOE JR.	000-00-0001	☒ M ☐ F	12-31-2004	SON
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON) (not requiring trustee)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section II-B Contingent Beneficiaries Have No Rights Unless All Primary Beneficiaries Have Died
I designate the following contingent beneficiary(ies) to receive the Retirement Systems refund of contributions or survivor benefits:

1. Name of Trustee(s), (attach Form 1113)	Trust ID, if applicable	Address of Trustee(s)		
ESTATE				
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON) (not requiring trustee)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section III BENEFICIARY(IES) FOR GROUP LIFE INSURANCE (You may not designate contingent beneficiaries for Group Life)
I designate the following beneficiary(ies) to receive the Retirement Systems Group Life Insurance:

1. Name of Trustee(s), (attach Form 1113)	Trust ID, if applicable	Address of Trustee(s)		
JOE DOE		1 RIVER DRIVE, COLUMBIA, SC 29229		
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex	Date of Birth	Relationship
JOHN DOE JR.	000-00-0001	☒ M ☐ F	12-31-2004	SON
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON) (not requiring trustee)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section IV CERTIFICATION AND CONDITIONS

IMPORTANT: Please read the Certification and Conditions sections of the instructions on the reverse (page 2) before signing this form. I hereby certify I have read and understand the information on the reverse (page 2), including the certification and conditions, and I agree to the provisions stated.

MEMBER'S SIGNATURE _____ WITNESS _____
(Do not print) (Required only when signed by mark)

STATE OF _____ COUNTY OF _____

Acknowledged before me this date _____ NOTARY NAME _____

My Commission Expires _____ NOTARY SIGNATURE _____
(Out of state, requires Seal)

Please call SC Retirement Systems Customer Service with any questions: 800/868-9002 (in state) or 803/737-6800

Form 1113
Certificate of Trust

Form 1113
05/29/2002
Page 1 of 2

CERTIFICATION OF TRUST

State Budget and Control Board
South Carolina Retirement Systems
Attention: Enrollment
Box 11960, Columbia, SC 29211-1960

Retirement Plan (check one)
☐ SCRS ☒ PORS
☐ JSRS ☐ GARS
☐ State ORP

PERSONALLY APPEARED before me, JOHN DOE
(Member Name)
(SSN: 000-00-0000), who being duly sworn, deposes and says:

1. I certify that I desire to designate a trust to receive my South Carolina Retirement Systems benefits.

2. I certify that the following person will serve as Trustee of my trust: ANN STONE
(Trustee Name)
3 MAIN STREET (Trustee Address) 803-000-1111 (Trustee Telephone)

3. I certify that the following person(s) are beneficiary(ies) of the trust:

	Name of Beneficiary	Social Security #	Date of Birth (MM-DD-YYYY)
a.	JANE DOE	111-11-1111	09-01-2005
b.			
c.			
d.			

MEMBER'S SIGNATURE _____ (Do not print) WITNESS _____ (Required only when signed by mark)

STATE OF _____ COUNTY OF _____

ACKNOWLEDGED BEFORE ME THIS DATE _____ NOTARY NAME _____

MY COMMISSION EXPIRES _____ NOTARY SIGNATURE _____ (Out of state requires Seal)

Please call SC Retirement Systems Customer Service with any questions: 800/868-9002 (in state) or 803/737-6800

Retirees Returning to Covered Employment

Retirees Returning To Covered Employment

- **Retirees returning to covered employment must complete Form 1114 (*Notification of Employed Retiree*). Form 1114 should be submitted within 30 days of the retiree's hire date.**

- **Retirees returning to covered employment should complete and sign Form 7201 (*Retired Member Change of Beneficiary Form*) to change their Group Life Insurance beneficiary.**

Form 1114
Notification of Employed Retiree

Form 1114
Revised 07/11/2005
Page 1

Print or type in black ink and sign in blue ink. Please read the instructions on page 2 before completing this form.

NOTIFICATION OF EMPLOYED RETIREE

State Budget and Control Board
South Carolina Retirement Systems
Attention: Enrollment
Box 11960, Columbia, SC 29211-1960

SECTION I — EMPLOYEE INFORMATION

1. Last Name & Suffix (PLEASE PRINT)	2. First/Middle Name (PLEASE PRINT)	3. Social Security Number
DOE	JANE	000-00-0000

4. Address	5. City	6. State	7. ZIP+4
1 MAIN STREET	COLUMBIA	SC	29229

8. Sex	9. Date of Birth	10. Date Returned To Work	11. Position Title	12. Present Monthly Salary
☐ M ☒ F	11-28-1938	07-01-2006	ADMINISTRATIVE ASSISTANT	2,000.00

13. Date of Retirement 07-01-1999

14. System Retired Under ☒ SCRS ☐ PORS

SECTION II — EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby notify you that I am an employee of the state of South Carolina or its political subdivisions, and that I am a retiree of one of the systems covered by the South Carolina Retirement Systems. As a retired member returned to covered employment, I understand that I am required to pay contributions at the same rate as active members. I also understand that I will not accrue any additional service credit. However, the contributions will be credited to my account and upon my death, any remaining contributions that have not been exhausted through benefit payments will be paid to my beneficiary.

I take this action under the provisions of the Retirement Act with full knowledge that I will not be credited with retirement service for this period of employment.

I also certify that the information provided in items 1-14 of Section I of this form are true to the best of my knowledge and belief.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Employee Signature: _____ Date: _____

SECTION III — TO BE COMPLETED BY THE EMPLOYER

The individual must be retired from the South Carolina Retirement Systems (includes SCRS TERI participants) or the Police Officers Retirement System. A retired SCRS or PORS member that returns to covered employment must make the same member contributions as an active employee. The employer must also make the same employer contributions for a retiree that is currently employed as they make for an active employee. The contribution rate should be based on the system in which a member is retired under. For example, a PORS retiree that returns to work under a position that would normally qualify as an SCRS position will contribute at the PORS rate. If a working retiree is receiving annuity benefits from both SCRS and PORS, retiree contributions should be reported based on the system for which an active member in the position would normally contribute.

Please indicate which system the member will be contributing: ☒ SCRS ☐ PORS

I hereby certify that the employee listed in items 1-2 of Section I of this form is a retiree returning to covered employment.

Employer Name: ANY EMPLOYER Employer Code: 000.00

Employer Signature: _____ Date: _____

Title: BENEFITS ADMINISTRATOR Work Telephone: 803-123-4567

Please call SC Retirement Systems Customer Service with any questions: (800) 868-9002 (in state) or (803) 737-6800

Form 7201
Retired Member Change of Beneficiary Form

Form 7201
Revised 01/10/2006

Please read the attached 2 pages of instructions before completing this form.

RETIRED MEMBER CHANGE OF BENEFICIARY FORM

South Carolina Retirement Systems
State Budget and Control Board
Box 11960, Columbia, SC 29211-1960

Section I

Retiree Last Name & Suffix	First Name/Middle Name	Social Security Number	System
DOE	JOHN	000-00-0000	☒ SCRS ☐ PORS

Mailing Address	City	State	Zip Code
1 MAIN STREET	COLUMBIA	SC	29229

Phone Number (Include area code)	Retirement Date	Date of Birth
803-123-4567	07-01-1998	01-02-1937

Section II — **RETIREMENT PAYMENT PLAN ELECTION AND BENEFICIARY DESIGNATION**

Current Beneficiary	Relationship	Current Option	Current Monthly Benefit
ESTATE			

QUALIFYING EVENT — DATE
- ☐ DEATH OF SPOUSE _____
- ☐ MARRIAGE _____
- ☐ DIVORCE _____
- ☒ OTHER _____

Death Certificate rec.	_____	(office use only)
Marriage License rec.	_____	(office use only)
Divorce Decree rec.	_____	(office use only)

Select a payment option if you have a change in marital status and wish to have your monthly benefit changed using the beneficiary information below. See explanation of options on the attached instructions. **Please attach copy of new beneficiary's birth certificate.** If previously requested, an estimated benefit recalculation is also attached.

☐ OPTION A (Maximum-Retiree Only) ☐ OPTION B (100% - 100% Joint Retiree-Survivor) ☐ OPTION C (100% - 50% Joint Retiree-Survivor)

If designating more than three beneficiaries, complete and attach an additional Form 7201. Beneficiary designations must be a person, an estate, or an artificial entity. ☐ Check here if payments are to be paid through a trust and attach a completed Form 1113, Certification of Trust.

	Social Security #/Federal ID#*	Sex	Date of Birth	Relationship (Check one)
1. Name of Beneficiary or Estate JOHN DOE JR.	000-00-0001	☒ M ☐ F	03-03-1987	☐ Spouse ☒ Son ☐ Daughter ☐ Other
2. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other
3. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other

Section III — **RETIREE GROUP LIFE INSURANCE** ☒ CHECK IF SAME BENEFICIARY(IES) AS IN SECTION II

Current Beneficiary	Death Benefit Amount
ESTATE	See Instructions

	Social Security #/Federal ID#*	Sex	Date of Birth	Relationship (Check one)
1. Name of Beneficiary or Estate	Social Security #/Federal ID#*	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other
2. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other
3. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other

*** If an "artificial" beneficiary such as a charity or funeral home is designated, a federal ID number must be furnished in the place of the Social Security number.**

Section IV — **SIGNATURE AND NOTARY STATEMENT**

Please read the Authorization section of the attached instructions before signing this form IN BLUE INK.

I hereby certify I have read and understand the information on the attached instructions, including the authorization, and I agree to the terms stated.

RETIREE'S SIGNATURE _____ DATE _____
(Certified copy of legal authorization required with signature other than applicant's)

WITNESS _____ DATE _____
(Required only when signed by mark)

STATE OF _____ COUNTY OF _____

Acknowledged before me this date _____ NOTARY NAME _____

My commission expires _____ NOTARY SIGNATURE _____

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (In state) or (803) 737-6800

Questions?